MONTANA EMERGENCY MEDICAL SERVICES FOR CHILDREN/CHILD READY MT

CONNECTION NEWSLETTER

VOLUME 3, ISSUE 5, MAY 2016

The May issue has many resources, educational opportunities and articles related to pediatric care throughout the contents. **Below is information on a 56 minute Montana PBS film written by students at the University of Montana.** ***On page 6 read Chris Benton's (Beartooth Billings Clinic Trauma Coordinator) article on the steps for becoming Pediatric Ready!*** **Page 7 has resource information for a 1 minute PSA on child drownings. Read page 8 to learn how many fatalities on Montana's roads and the causes so far this year!**

THINK, ACT, GROW: RESOURCES FOR PROMOTING ADOLESCENT HEALTH

Adolescence is an important time for promoting health and preventing disease, one that is sometimes overlooked. **Think, Act, Grow (T.A.G.)** is a national **call to action to improve adolescent health** in the United States. The website features **resources** **gathered with input from professionals** who work with adolescents in after-school or community-based programs, education, faith-based organizations, health care, public health, and social services settings.

Preventive healthcare services during adolescence can help protect them into adulthood; and positive health behaviors, such as exercising regularly and eating nutritious meals are often established during this period. **Public health is well-positioned to provide leadership for developing community approaches to promoting adolescent health**.

DISTRACTED: EYES OFF THE ROAD

Journalism students from the University of Montana have produced a **riveting documentary** that explores the **consequences of driving while distracted**.

The **56-minute Montana PBS film** highlights the stories of those who have experienced it firsthand.

It includes cellphone use; but goes beyond to focus on the mindset of a person behind the wheel.

This is a powerful learning opportunity for schools and community groups, and can **easily be utilized and beneficial for many audiences**

For more information go to http://watch.montanapbs.org/video/2365250868/

STRATEGIES FOR COMMUNICATING WITH CHILDREN DURING TRAUMA

• Approach from eye level.
• Use “minimally threatening” or “soft” language. Use direct phrases (i.e., describe an incision as “making a small opening” rather than a “cut” or “hole”)Avoid using the word “hurt” because it has nonspecific connotations, and doesn’t convey helpful information. Try “sting” or “prick” when preparing children for an IV.

• Give analogy for medical terms (e.g., shot, pressure dressing, stretcher or butterfly) - i.e., describe a tourniquet as a “big rubber band” (something familiar to most children).

• Don’t provide explicit detail.–**Only provide children with the information that they will directly experience**.–Too much information may confuse or frighten children.

• Have child repeat back what they’ve heard.
• Allow child to make choices.–“Some kids say it feels like a pinch or a sting. What do you think?”
• Restore sense of control.
• Give child autonomy over his or her body.
•Enable children to play an active role. - “Your job is to hold his hand” or sing the ABC song.

STRATEGIES FOR POST-TRAUMA MANAGEMENT OF CHILDREN

• Assign a single information provider for pediatric victims.–The absence of a trusting relationship is a cause of emotional distress.–Provide at least one care provider who is frequently and readily available.–Be mindful of nonverbal communications.

• Allow for “play therapy” during evacuation phase and after the event.
• Use drawings, medical tools, etc.
• May provide more information post-event than verbal interviews.

• Allow for family reunification.–**Emphasizing “family-centered care” fosters family unit autonomy. Keep parents with children. Keep siblings together.**–Increases familiarity for children affected by events (parental signaling).–Provide anticipatory guidance.

• Increase familiarity and predictability–Need to work closely with families to assess their understanding of the situation.–Anticipatory guidance will reduce emotional distress.

For more information on Tactical Emergency Casualty Care Pediatric Guidelines
See http://www.jems.com/articles/2014/09/tactical-emergency-casualty-care-pediatr.html

KEEPING OUR CHILDREN SAFE IN A CHANGING WORLD- EMSC NRC webinar

This webinar discusses how children can be especially vulnerable to unexpected crisis events, such as active shooter incidents, acts of terrorism, and other natural or human-caused disasters that strike without warning.

It is an interactive town-hall discussion where parents and caregivers learn about current and upcoming resources, and engage in an open discussion with experts about their biggest concerns for their children and what can be done to help keep them safe. (Video or Multimedia)

ROUTINE SCREENING OF EMERGENCY ROOM PATIENTS FOR SUICIDE RISK MIGHT BE AN EFFECTIVE WAY TO PREVENT IT (study published in the American *Journal of Preventive Medicine*.

Nurses at eight ERs were trained to screen patients for **three suicide risk factors: depression, suicidal thoughts and previous suicide attempts**. Over five years, suicide screenings rose from 26 percent to 84 percent, and detection of patients at risk of suicide increased from nearly 3 percent to 5.7 percent, the University of Massachusetts Medical School researchers found.

"Our study is the first to demonstrate that near-universal suicide risk screening can be done in a busy [emergency department] during routine care," lead author Edwin Boudreaux said in a university news release. Boudreaux is vice chairman of research in the department of emergency medicine.

"The public health impact could be tremendous, because identification of risk is the first and necessary step for preventing suicide," he added. Boudreaux noted that patients who were found to be at risk were further evaluated and provided with resources that they otherwise would not have received.

"In fact, with screening we identified a subset of patients [10 percent] whose suicidality was serious enough to warrant psychiatric inpatient treatment. What would have happened to them if they had been discharged? The conventional wisdom is that at least some of those individuals would have tried to kill themselves," he noted.

The other 90 percent of patients who screened positive for suicide risk were discharged with resources such as a self-help safety plan, lists of community services and a wallet card with contact information for local suicide prevention hotlines.

PEDIATRIC TRAUMA-A MULTI—SYSTEMS APPROACH

This is an exciting virtual online course for all healthcare providers that present *A Multi–Systems Approach to Pediatric Trauma*.
This is true "edutainment" with streaming video, rich multimedia and interactive instruction.

A pediatric trauma scenario is filmed with talented volunteers who act out the scenes. The filmed interview portion comments on and discusses the scenario to provide the teaching and instruction.

Flash animated **Video Recap**s and interactive **Apply Your Knowledge** questions complete the repeating format. Each module presents a different facet of the **Multi–Systems Approach** and how they interface and interact together to medically treat the pediatric trauma patient.

These multi-systems are described below and are covered in the course.

· Trauma to different body systems in children (head neck & spine; abdomen & chest; musculoskeletal...)
· Care and treatment by various healthcare providers (i.e. physicians, nurses, paramedics, EMT's)
· Patient presentation to various healthcare facilities, rural & urban, for care (i.e. clinics, local emergency room, major trauma center
· Various transport modes (i.e. fire EMS, ambulance, helicopter)
· Preparation for pediatric trauma in various settings (i.e. EMS, ER, clinic)

OTHER MODULES INCLUDE:

MODULE 1: PEDIATRAIC SEIZURES CE 1.0

MODULE 2: DIABETES IN CHILDREN CE 1.0

MODULE 3: BLUNT CHEST TRAUMA-COMMONTION CORDIS CE 1.0

MODULE 4: METHAMPHETAMINE IN CHILDREN CE 1.0

MODULE 5: CHILDREN WITH SPECIAL HEALTHCARE NEEDS PART 1- DOWN SYNDROME CE 1.0

MODULE 6: CHILDREN WITH SHCN PART 2- TECHNOLOGY DEPENDENT CHILDREN CE 1.0

MODULE 7: CHILD ABUSE/SHAKEN BABY SYNDROME CE 1.0

MODULE 8: POISONING/TOXIC EXPOSURE CE 1.0

MODULE 9: ADRENAL CRISIS AND EMS CE 1.0

MODULE 10: SAFE TRANSPORT OF CHILDREN IN EMS VEHICLES PART 1 CE 1.0

MODULE 11: SAFE TRANSPORT OF CHILDREN IN EMS VEHICLES PART 2 CE 1.0
http://emed.unm.edu/pem/programs/ems-for-children-emsc/emsc-online-course-directory.html

PEDIATRIC EMERGENCIES:

This is an exciting virtual online course for all healthcare providers that present pediatric emergencies. **It is a companion course to *A Multi–Systems Approach to Pediatric Trauma*- but differs in that education focuses on emergency care for the ill child.**

The course is also scenario based with streaming video, rich multimedia and interactive instruction.

The module format utilizes a user friendly, visually interesting interface to navigate through the pages.

http://emed.unm.edu/pem/programs/pediatric-emergencies-course/index.html

PEDIATRIC EMERGENCY CARE *COORDINATORS* AND DISASTER PREPAREDNESS: ENSURING DAY-TO-DAY READINESS FOR CHILDREN

This 51-minute webinar, part of the Emergency Medical Services for Children Communities of Practice series, discusses the importance of pediatric emergency care coordinators and their role in pediatric disaster preparedness. Leaders and champions from within the community, as well as specially invited guests from across the country, share ideas and best practices, discuss challenges, and identify resources for the development and support of pediatric disaster preparedness leadership in the local, state, or regional disaster preparedness community.

(Video or Multimedia) Children's National Health System, Emergency Medical Services for Children National Resource Center.

THE DANGERS OF LAUNDRY DETERGENT PODS

Despite repeated warnings about the dangers to young children from laundry detergent pods, calls to poison control centers continue to rise, a new study shows. Researchers found an increase **of nearly 20 percent in reports of children putting the brightly colored packets into their mouths**, with serious and sometimes even fatal consequences, according to the study published in Pediatrics.

The Center for Injury Research and Policy at Nationwide Children's Hospital reported that during the two years of this study they saw an increase in the number of exposures to detergent, especially exposures to laundry detergent packets. **In fact, a child is reported to a poison control center about every 45 minutes in this country."**

Researchers analyzed data from 62,254 calls made in 2013 and 2014 to U.S. poison control centers reporting unintentional exposures to laundry or dishwasher detergent among children younger than 6. **Calls increased for all types of detergent exposures, but the rise was greatest for the highly-concentrated laundry detergent pods (17 percent); followed by dishwasher detergent packets (14 percent).** Laundry pods are the most hazardous, particularly when the packets contain liquid detergent rather than granules. **The harms to children from laundry pod ingestion included coma, respiratory arrest, pulmonary edema and cardiac arrest. According to The American Association of Poison Control Centers symptoms of ingesting a pod can include excessive vomiting, wheezing, breathing problems or sleepiness**

Earlier this year two lawmakers took a stab at reducing the damage by introducing a bill, the Detergent Poisoning and Child Safety Act that would require safety standards for the products. The bill was put on hold after pod manufacturers agreed to make changes to their products, which included adding a bitter tasting packet coating and using containers that were harder to open, according to a Wall Street Journal report.

Researchers are "**strongly recommending" that parents not use laundry detergent packets if there are young children at home but to use traditional laundry detergent**. To keep children safe, always keep detergent containers closed, sealed and stored up high, out of the reach of children.

.. danger of laundry pods to children information
http://www.today.com/health/never-seen-anything-more-children-harmed-ingesting-laundry-pods-t88036

Call your local poison center at 1-800-222-1222 immediately if a child is believed to have come in in contact with detergent or a laundry pod.

QUOTE OF THE WEEK

The art of mothering is to teach the art of living to children. **~Elaine Heffner**

HAPPY MOTHER'S DAY TO ALL MOTHERS

PEDIATRIC PREPARED FACILITY: A COLLABORATIVE APPROACH (Chris Benton, Trauma Coordinator & Pediatric Readiness Committee Chair-Beartooth Billings Clinic)

Beartooth Billings Clinic acquired recognition as a "**Pediatric Prepared Facility**" in February 2016. We achieved this recognition by including the entire local Trauma system, and various providers within Carbon County. The collaborative effort offered an understanding of each organization's capacities and limitations for pediatric patient care (Beartooth Billings Clinic {multiple internal departments}, Red Lodge Fire/Rescue EMS, Mountain View Clinic (of St. Vincent's Hospital) and Red Lodge Mountain Ski Patrol. **As a system we can proceed to improve our skills, policies/guidelines, and protocols which in turn will improve our capacity to be better prepared to care for this patient population.** For the past 8 years we have worked tirelessly to expand the definition of our trauma system beyond the walls of the hospital. The relationships built over time, gave us the foundation necessary to include other organizations in the process for certification of pediatric readiness. We were able to utilize this pre-existing mutual respect to address the basic question that we all face: **"How can we best serve the pediatric patient and the families of our community?"**

We knew the organizations would be interested in each other's' policies and procedures. We were cognizant of the time commitment necessary to achieve this level of sharing. We used a formula of open communication and delegation to keep joint meetings to a minimum. As the lead agency, we proceeded with a series of steps and task assignments within a designated timeline. The success of the project was based on a format that allowed each organization to identify their own answer to the question "**What would we do if a sick or seriously injured pediatric patient presented to us?"**

First Step: Committee Chair and Co-chairs were identified. It was these individuals that were responsible for compiling information throughout the process and ultimately with the final presentation.

Second Step: Invitations to participate were sent to our local trauma system-prehospital and in hospital that would care for the seriously ill or injured pediatric patients including Beartooth Billings Clinic (Clinic, ED/Trauma, specific ED/AC Nursing staff, Medical Advisor {Trauma Medical Director}, Administration, Radiology, Laboratory, Physical Therapy, Children's Center, Emergency Preparedness, and Public Health), local clinics, EMS, and ski hill. We were succinct in our expectations of sharing existing policy/guidelines with the intent **to work towards system improvement for the pediatric patient**.

Third Step: Compiled current two year statistics i.e., **number of pediatric patients-**cared by whom and ages. This information was consistent with the definition of pediatric trauma ages 0-18 and coincided with the pediatric population seen in each agency. **The data was broken down into 3 categories; medical, minor injuries, and major injuries (**determined by injury type and seriousness.)

Fourth Step: The initial joint meeting occurred 3 months prior to the review date with 22 participants representing 11 from hospital departments and 6 from organizations. Statistics were shared and participants discussed their 'care' for pediatric patients. **All participants committed to the process and goal of improving our system's care and preparedness for the pediatric patient**.

Fifth Step: Individual departments and organizations worked independently to gather current information on pediatric readiness, identification of policy/guideline improvements, and development of protocols that were necessary to meet the requirements for the recognition criteria. This information was reviewed by the Chair and Co-chair.

Sixth Step: Chair and Co-Chair provided follow-up to assure that all components of the required State criteria were met. Policies/guidelines, procedures and protocols were compiled and copies were given to all participants**. Final product was prepared and presentation given to the EMSC Review Team.**

As a rural Trauma Receiving Facility it has proven invaluable to include as many of the different providers that are involved in pediatric care. This collaborative effort offers a win-win situation for patient as well as caregivers. The certification has officially been presented to Beartooth Billings Clinic, **yet it took the 'village' to recognize that the system of care for all pediatric patients**. There is ongoing education and inter - organization involvement to solidify this process.

QUICKLY AND SILENTLY: CHILDREN CAN DROWN INSIDE THE HOME

Every year, nearly 90 children drown inside the home, and two-thirds of these deaths occur in the bathtub. **A child can drown in as little as 2 inches of water**, and it happens quickly and silently. **Every one of these tragedies is preventable**. This 1-minute PSA demonstrates the importance of constant supervision. Parents and guardians should never leave a child alone in the bathtub or near any container of water. Turning their backs for a moment can change their lives forever.

QUIT LINE: TARGETED RESOURCES FOR PREGNANT & AMERICAN INDIAN SMOKERS

A new Montana Tobacco Quit Line program for American Indian smokers connects them with **Native Coaches**, offers 10 weeks of **free counseling**, and free **Nicotine Replacement Therapy**. This service uses a dedicated line number: 1-855-372-0037.

Another **program for pregnant and postpartum smokers** who wish to quit provides a dedicated **female coach**, extended coaching calls with **cash incentives**, a **personalized quit plan**, and **Nicotine Replacement Therapy** support. Women who are interested can call 1-800-784-8669 to enroll or visit the website.

CERTIFIED CAR SEAT INSTALLATION TRAINING – UPCOMING LOCATIONS & DATES

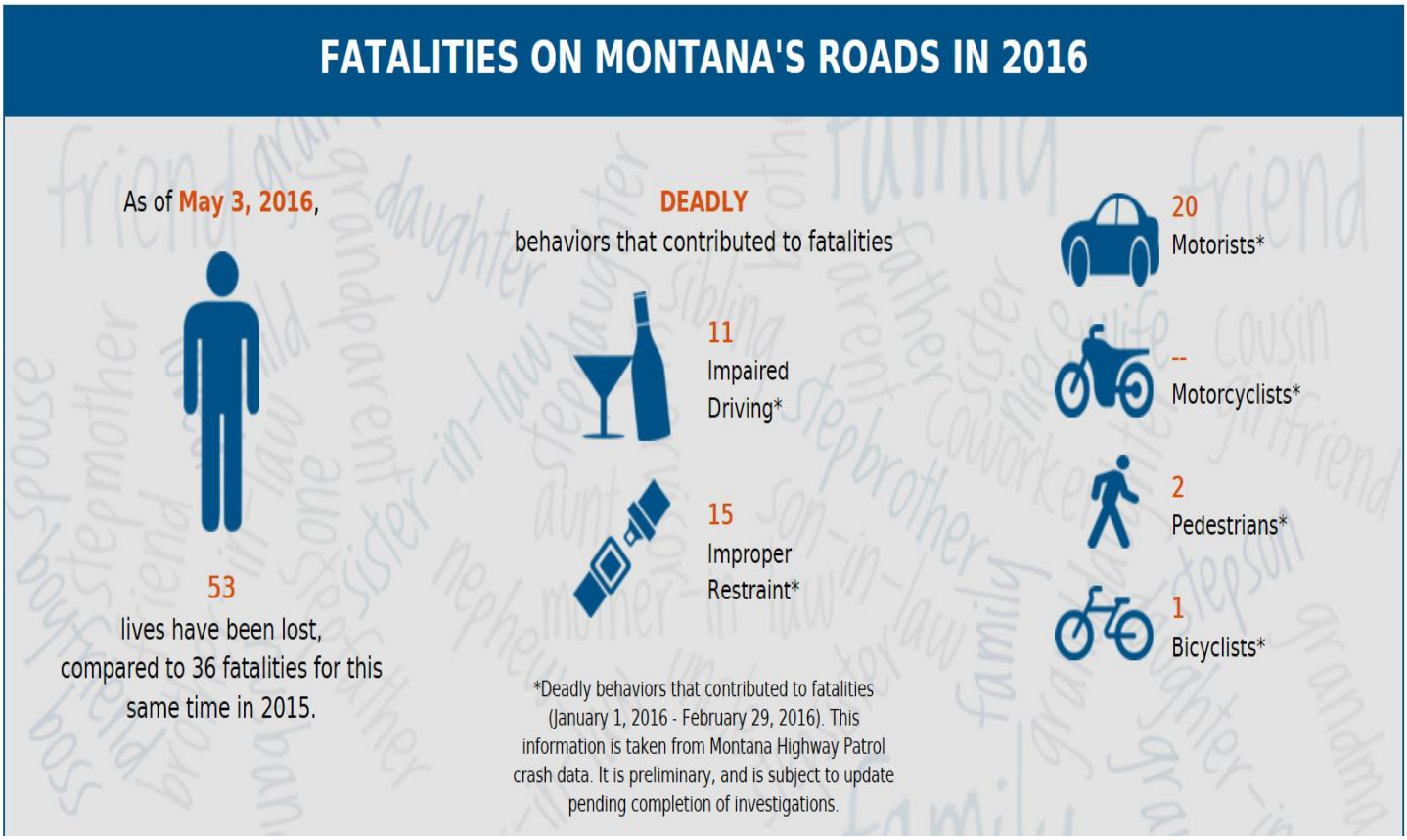
Make a difference and **help ensure little ones are safer while traveling**. Learn new skills to teach parents and caregivers about proper carseat safety for children.

Visit the Montana Department of Transportation's website for more details. More than half of Montana's counties do not have a certified carseat installer. Depending on circumstances, registration scholarships and travel stipends may be available.

See more information at cps training dates and information
https://www.mdt.mt.gov/publications/docs/brochures/safety/cps-training-dates.pdf

TRAINING DATES AND CITIES: BILLINGS, JUNE 8-11 AND GLENDIVE, JULY 11-14

FATALITIES ON MONTANA ROADS 2016



SIDS OR SUDDEN INFANT DEATH

Training- updated, **free continuing education (CE) activity is now available online** for nurses and health care providers to update their knowledge about **Sudden Infant Death Syndrome (SIDS**) and other sleep related causes of infant death.

The updated CE activity gathers the latest research on SIDS and other sleep-related causes of infant death and the safe sleep recommendations from the American Academy of Pediatrics into one place so that **nurses and health care providers can learn risk-reduction practices quickly and easily**.

In addition to providing key messages that nurses can share with parents and caregivers, the updated CE activity also offers specific communication practices that nurses can easily incorporate into their work day. It is approved by the Maryland Nurses Association, an accredited approver of the American Nurses Credentialing Center's Commission on Accreditation, for 1.1 contact hours.

Safe to Sleep® campaign - Office of Communications, *Eunice Kennedy Shriver* National Institute of Child Health and Human Development National Institutes of Health

risk reduction for sudden infant death syndrome
https://www.nichd.nih.gov/sids/Pages/sidsnursesce.aspx?utm_source=EB&utm_medium=NursesCE&utm_campaign=STSCommunity&mc_cid=64db3b2f01&mc_eid=8e66b2fac0

TRIVIA

Answer the trivia and win free give away gifts for EMSC Day May 18th-pediatric first aid slide guides-first 4 to email answers to Robin -rsuzor@mt.gov NOT to the listserve.

1. When is EMS for Children's Day in 2016?
2. What is one of the dangers of laundry detergent pods?
3. What is the poison control number?

Each year, the Federal E.M.S.C. program partners with the American college of emergency physicians (A.C.E.P.), the American Academy of Pediatrics (A.A.P.), and the Emergency Nurses Association (E.N.A.) to celebrate E.M.S. for Children day-to be held on May 18, 2016, the Wednesday of Emergency Medical Services (E.M.S.) week, May 15-21, 2016.

The purpose of the annual celebration is to raise awareness about the need to improve and expand specialized care for children in the prehospital and acute care settings. Listed on the webpage are the primary messages for the 2016 celebration, organized by the program's key audiences: hospital personnel, ems providers, and parents/caregivers.

For more information about E.M.S. Week, how to celebrate, call attention to, and honor those who provide the day-to-day lifesaving services of medicine's "front line," download a copy of A.C.E.P.'s 2016 E.M.S. week planner or become a fan of the National E.M.S Week Facebook page.

LET ME KNOW HOW YOU CELEBRATED THE 2016 EMSC DAY OR EMS WEEK!

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